PRINTED: 08/30/2019 FORM APPROVED

| CENTERS FOR MEDICAR | E & MEDICAID SERVICES | | OMB NO. 0938-039 |
|--------------------------|-----------------------------|--|------------------|
| TATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY |
| ND PLAN OF CORRECTION | IDENTIFICATION NUMBER | | COMPLETED |

S B, WNG 495320 08/21/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 HERITAGE HALL CLINTWOOD CLINTWOOD, VA 24228 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) (E 000) (E 000) | Initial Comments (F 000) | INITIAL COMMENTS (F 000) An unannounced Medicare/Medicaid revisit to the standard survey conducted 06/18/19 through 06/20/19, was conducted 08/20/19 through 08/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long MECE VED Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. VDH/OLC The census in this 100 certified bed facility was 89 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 101 through 113). F645 {F 645} (F 645) PASARR Screening for MD & ID Corrective Action(s) SS=D | CFR(s): 483.20(k)(1)-(3) Resident #108's attending physician and responsible party have been notified that §483.20(k) Preadmission Screening for the facility failed to obtain a level I individuals with a mental disorder and individuals PASRR for the resident prior to their with intellectual disability. admission. A facility Incident & Accident form has been completed for §483.20(k)(1) A nursing facility must not admit, on this incident. or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) Resident #113's attending physician and (i) of this section, unless the State mental health responsible party have been notified that authority has determined, based on an the facility failed to obtain a level I independent physical and mental evaluation PASRR for the resident prior to their performed by a person or entity other than the admission. A facility Incident & State mental health authority, prior to admission, Accident form has been completed for (A) That, because of the physical and mental this incident. condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID: VA0109

Any deficiency statement ending with an asterisk (*) dendtes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

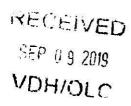
| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 0.0000 | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|--------------|------|--|---|----------------------------|
| | | | 1 20125 | | | F | ₹ |
| | | 495320 | B. WING | | | 08/ | 21/2019 |
| NAME OF P | ROMDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| HERITAGI | E HALL CLINTWOOD | • | | | 25 CLINTWOOD MAIN STREET, ROUTE 607 PO | BOX 909 | |
| (IEIGITA) | | | | CL | INTWOOD, VA 24228 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | 25.5 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 645) | (k)(3)(ii) of this section intellectual disability authority has determined. A) That, because of condition of the individual reservices, whether the specialized services. §483.20(k)(2) Except section— (i) The preadmission paragraph(k)(1) of the for determinations in to a nursing facility obeing admitted to the transferred for care in (ii) The State may chap paragraph (k)(1) of the total nursing facility of the analysis of the section of | individual requires or ity, as defined in paragraph in, unless the State or developmental disability ined prior to admission- the physical and mental dual, the individual requires provided by a nursing facility; equires such level of a individual requires for intellectual disability. Itions. For purposes of this escreening program under its section need not provide the case of the readmission of an individual who, after a nursing facility, was in a hospital, loose not to apply the ling program under his section to the admission | {F 6 | 645} | Identification of Deficient Practices & Corrective Action(s): All other residents who were required have a PASRR prior to admission may have been affected. The social service director/designee will complete a 100 review of all residents to identify residents without a level 1 PASARR. Physicians and RP's of resident's four beat risk will be notified at the time of discovery. A facility Incident & Acciform has been completed for each incident. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The admission director, social worker, DON, and administrator have been inserviced by regional nurse consultant on the requirement that residents with a men disorder have a PASRR be completed prior to admission Monitoring: The social worker/designee will be responsible for maintaining compliant Potential new residents will be revier prior to their admission to ensure that PASRR has been completed if indicated to the process of th | nd to of ident y the ntal i t a nted. at the to the and | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID: VA0109

If continuation sheet Page 2 of 32



PRINTED: 08/30/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROMDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING _ R B. WING 495320 08/21/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 HERITAGE HALL CLINTWOOD CLINTWOOD, VA 24228 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 645} Continued From page 2 {F 645} section-(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by Based on staff interview, facility document review, and clinical record review, the facility staff failed to perform a level I PASARR (preadmission screening and resident review) for 2 of 13 Residents, Residents #113 and #108. The findings included: 1. For Resident #113, the facility staff failed to complete a level I PASARR. A PASARR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. The Residents face sheet revealed that Resident #113 had been admitted to the facility 12/05/12 and was readmitted on 07/11/19. This face sheet

included the following diagnoses depressive disorder, anxiety disorder, essential hypertension, muscle weakness, and pain.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/29/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID VA0109

If continuation sheet Page 3 of 32



PRINTED: 08/30/2019 FORM APPROVED

OMB NO. 0938-0391

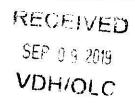
| OCITICAL | O . OIT MEDIONITE OF | MEDIONID OCITATOCO | | | ONID 110. 0000-0001 |
|--------------------------|--|--|---------------------------------------|--|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING | ONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495320 | B. WING | | R |
| | | 1770220 | | | 08/21/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | |
| HEDITAGE | E HALL CLINTWOOD | | 122 | 5 CLINTWOOD MAIN STREET, ROUTE 607 PO | BOX 909 |
| HERHAOL | - HALL CLINTIFOOD | | CLI | NTWOOD, VA 24228 | 7/28/28/40/20/20/20/20/20/20/20/20/20/20/20/20/20 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | D.T. |
| {F 645} | Continued From page | e 3 | {F 645} | | |
| | POC (plan of correction of nursing), the DON facilities credible evid This document was tion of this Residents namedocumented "out of state)." The DON was clarification as to why the DON referred the (social worker). During an interview was 1:23 p.m., the SW verthis Resident did not | The state of the s | 9 | | |
| | from Virginia DMAS (assistance services) the process to ensure facilities had a level I On 08/21/19 at 2:20 the surveyor that the information in regards | red with the DON a letter department of medical dated 11/19/18 that outlined e Residents in nursing PASARR in place. b.m., the DON verbalized to SW had been using other is to obtaining PASARR's. No on was given to the survey | X X X X X X X X X X X X X X X X X X X | | |
| | "Identification of Defination (s)The social Admissions director of all residents to ide level II PASRR (sie) of but did not have one. | n of correction) read in part, cient Practices & Corrective services director and/or will complete a 100% review nitify residents who needed a completed prior to admission. All negative findings will be of discoveryCompletion | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID VA0109

If continuation sheet Page 4 of 32



| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILOII | | STRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|-------------------------|----------|---|--|
| | | 495320 | B. WNG_ | | | R 08/21/2019 |
| | ROVIDER OR SUPPLIER | | | 1225 CI | ADDRESS, CITY, STATE, ZIP CODE LINTWOOD MAIN STREET, ROUTE 607 PO WOOD, VA 24228 | M ANARAT NO CONTROL OF STATE O |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 322 |
| {F 645} | nurse consultant were regarding Resident # | DN (director of nursing), and | · {F 6· | 45} | | EF AT |
| | No further information | regarding this issue was y team prior to the exit | E | | | • |
| | ensure a level 1 PAS | the facility staff failed to RR (pre-admission ant review) was completed. | | | | |
| | date of 03/20/07 and 02/02/19. The Reside diagnoses of, but not hypertension, anemia | a, intellectual disabilities, allergic rhinitis, and | | F | | e E |
| | (minimum data set) w reference date) of 08/ | ef interview for mental | | | | |
| | clinical record was resurveyor could not loo of the clinical record. DON (director of nurs | ection of Resident #108's viewed on 08/21/19. The cate a PASRR in this section Surveyor spoke with the ing) and informed her that a located. DON stated she | | | | er e |

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

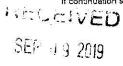
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A BUILDIN | IPLE CONSTRUCTION NG | COMPLETED |
|--------------------------|--|--|------------------------|--|--|
| | | 495320 | B, WING_ | | 08/21/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLETION |
| (F 645) | approximately 10:18 worker, Resident #1 "because he's been that Resident #108 assessment instrum The concern of Resident passes in his clinicative teatments. | the surveyor on 08/21/19 at 5 am that, per the social 108 would not have a PASRR here 31 years". DON stated did have a UAI (uniformment) in his clinical record. Sident #108 not having a all record was discussed with eam (administrator, DON, soutant) on 08/21/19 at | {F 6 | 45) | 7. |
| {F 684} SS=D | Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a re that residents recei accordance with propractice, the compresse plan, and the interest This REQUIREMENT by: Based on staff interest and facility document to ensure that residents received 13 residents, Research | fundamental principle that then and care provided to assed on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced enview, clinical record review ent review the facility staff failed eved treatment and care for 2 sidents #104 and #101. | {F € | F684 Corrective Action(s): Resident #104's attending notified that the facility state follow physician's orders from administration of Lonhala I medication. A facility Incident. Resident form was completed incident. Residents #101's attending was notified that the facility provided restorative nursing the resident without a physical A facility Incident & Accident for this incident. | ff failed to or the Magnair dent & ted for this physicians y staff g services to ician's order. lent form was |
| | | 04 the facility staff failed to orders for the administration of | | 1 2 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID: VA0109

If continuation sheet Page 6 of 32



PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT (| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE | |
|--------------------------|--|---|-------------------|------|--|---|----------------------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER. | A, BUILDI | NG | | | ₹ |
| | | 495320 | B. WING | | and the same of th | | 21/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | E | | 12: | 25 CLINTWOOD MAIN STREET, ROUTE 607 PO | BOX 909 | |
| HERITAGI | E HALL CLINTWOOD | | | CL | INTWOOD, VA 24228 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 684} | to the Physician's Deinhaled medication unchronic obstructive pure to the Physician's Deinhaled medication untreatment of chronic disease. Resident #104's face date of 11/29/12 and 03/01/19. The resided diagnoses of, but not deficiency, hypertenshyperplasia, coal work anxiety, diverticulitis, obstructive pulmonal rhinitis, anemia, dyspand hypothyroidism. The most recent quaset) with an ARD (as 07/30/19 assigned thinterview for mental in section C, cognitive The physician's order clinical record were signed physician's order clinical record were signed physician's order clinical record were signed physician's order (nebulizer) q12h (ev 15 mcg/2ml Soln (sold Resident #104's eM administration record reviewed and contain part "Brovana 15 metreatment Q 12 hour treatment Q 12 hou | nala and Brovana. According ask Reference, Brovana is an sed in the treatment of ulmonary disease. According ask Reference, Lonhala is an sed in the maintenance obstructive pulmonary e sheet listed an admission a readmission date of ant's diagnosis list included thimited to Vitamin B12 sion, benign prostatic rker's pneumoconiosis, hearing loss, chronic ry disease, insomnia, allergic obagia, pain, constipation, arterly MDS (minimum data is sessment reference date) of the resident a BIMS (brief status) score of 14 out of 15 | (F 6 | 884} | Identification of Deficient Practices/Corrective Action(s): All residents may have potentially be affected. A 100% review of all residented medication orders has been conducted the DON/designee identify residents risk. Residents found to be at risk demedications being unavailable from pharmacy will be corrected at time of discovery and their attending physician will be notified. A facility Incident a Accident form has been completed freech. The DON/designee will conduct a 10 review the facility's restorative nursing treatment logs to identify resident will may be receiving Restorative Nursing Services without an appropriate physician's order. Residents identifier risk will be corrected at time of discound the attending physician will be notified of each negative finding and facility Incident & Accident form completed. Systemic Change(s): The facility policy and procedures to been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by 24Hour Report and documentation is medical record /physician orders renthe source document for the develop and monitoring of the provision of cwhich includes, obtaining, transcribinand administering physician ordered medications, treatments and nursing services. The DON and/or Regional consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and complet physician medication and treatment orders. To include following and | ent's ed by at at ue the the f ians and or 00% ing ho ag d at overy I a ave the nains ment arc, ng nurse ing | |

Facility ID: VA0109

| CENTER | S FOR MEDICARE & I | MEDICAID SERVICES | | | OMB NO, 0938-0391 |
|--------------------------|---|---|---------------------|---|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | g 05 86 | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED |
| | | 495320 | B. WING_ | | R 08/21/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | - | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | 19 | | 1225 CLINTWOOD MAIN STREET, ROUTE 607 | PO BOX 909 |
| HERITAGE | E HALL CLINTWOOD | | | CLINTWOOD, VA 24228 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| {F 684} | at both 8 am and 8 pr was coded with "N" o both 8 am and 8 pm. 08/13/19 at 8 am. The medication was not a The notes section of contained notes, whice 8/10/19 Brovana 15 ntrscheduled for 08/10/2019 8:00 AM administered-Other.pclarification", "12:00A mcg/2ml solution via 08/10/2019 8:00 PM administered-Other.pclarification", "12:00A mcg/2ml solution via 08/10/2019 8:00 PM administered-Other.pclarification", "12:00A 25 mcg Starter Q 12 08/10/2019 8:00 PM administered-Other.pclarification", "9:30AM mcg/2ml solution via 08/11/2019 8:00 AM administered-Other.pclarification", "9:30AM mcg/2ml solution via 08/11/2019 8:00 AM administered-Other.pclarification", "9:30AM administered-Other.pclarification", "9:30AM administered-Other.pclarification", "9:30AM pending provider clar Brovana 15 mcg/2ml trscheduled for 08/1 administered-Other.pc | N" on 08/10/19 and 08/11/19 n. The entry for the Lonhala n 08/10/19 and 08/11/19 at and on 08/12/19 and e entry indicated that the dministered. the eMAR was reviewed and the read in part, "9:06AM, ncg/2ml solution via neb 10/2019 was not ending provider 1, 8/10/19 Lonhala Magnair nouscheduled for was not ending provider M, 08/11/19 Brovana 15 neb trscheduled for was not ending provider M, 8/11/19 Lonhala Magnair houscheduled for was not ending provider M, 8/11/19 Brovana 15 neb trscheduled for was not ending provider M, 8/11/19 Brovana 15 neb trscheduled for was not ending provider M, 8/11/19 Brovana 15 neb trscheduled for was not ending provider M, 8/11/19 Lonhala Magnair nouscheduled for was not administered-Other iffication", "11:16PM, 8/11/19 solution via neb 11/2019 8:00 PM was not ending provider M, 8/11/19 Lonhala Magnair nouscheduled for was not | {F 68 | providing Restorative nursing service physician order. The Pharmacy Policy and Procedur been reviewed and no changes are warranted. All licensed nursing staff been inserviced on the Policy and Procedure for medication administration included medications that are unavailable or do not arrive at the fittimely from the pharmacy for administration. The inservice will in the steps the nurses should take sho medication not be delivered timely the pharmacy Monitoring: The DON will be responsible for maintaining compliance. The DON/designee will perform no less MAR reviews/week to monitor for compliance; and also a weekly reviofRestorative Nursing flow sheets a to monitor for compliance will be completed. Any/all negative finding or errors will be corrected at time of discovery and disciplinary action we taken as needed. Aggregate finding these audits will be reported to the Quality Assurance Committee quar for review, analysis, and recommendations for change in face policy, procedure, and/or practice. Completion Date: 9/13/19 | e has f have ation acility nclude uld a from than 2 ew audits s and f ill be gs of terly |

| 5 1815 | | |
|---|--|-----------------|
| 495320 B, WING | | R 08/21/2019 |
| HERITAGE HALL CLINTWOOD | EET ADDRESS, CITY, STATE, ZIP CODE 5 CLINTWOOD MAIN STREET, ROUTE 607 PO B NTWOOD, VA 24228 | 3OX 909 |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| (F 684) Clarification", "9:11AM 8/12/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/12/2019 8:00 AM was not administered-Other.pending provider clarification.medication on order per pharmacy" and "11:43AM, 8/13/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/13/2019 8:00 AM was not administered-Other.pending provider clarification.pending arrival form pharmacy the device to deliver the dose, MD notified". The surveyor spoke with LPN (licensed practical nurse) #1 on 08/21/19 at approximately 8:00 am regarding Resident #104's medications. LPN #1 stated that the medication was not available from the pharmacy. Also stated that it took longer for the Lonhala to arrive from pharmacy due to needing a special nebulizer kit. The surveyor spoke with pharmacist #1 on 08/21/19 at approximately 9:15 am regarding Resident #104's medications. Pharmacist #1 stated the Brovana was sent out on 08/08/19 on the 9 pm pharmacy run. Pharmacist stated that a 30-day supply of the medication was sent at this time. Pharmacist #1 stated that a refill for the Lonhala was sent at the same time as the Brovana. Pharmacist #1 also stated that the Lonhala starter kit was not sent until 08/12/19 on the 1 pm pharmacy run. This was due to having to special order the starter kit, and it did not come in until then. The surveyor requested a copy of the pharmacy manifest for Resident #104. This was provided to the surveyor on 08/21/19 at approximately 2:10 pm. The pharmacy manifest indicated that Resident #104's Brovana was received at the facility on 08/09/19 at 12:16 AM. The pharmacy | | |

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A BUILDI | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
|----------------------------|--|--|-----------------------|--|-----------|----------------------------|
| | | 495320 | B. WING_ | | | R 08/21/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228 | | 9 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFU TAG | PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| {F 684} | Magnair Starter kit w 08/12/19 at 6:51 PM. The surveyor spoke of nursing on 08/21/19 regarding Resident # not confirm why Resident # not confirm with an ARD (assess 08/13/19 had been confirmed in the problem of the sident had problem in the sident had problem of the sident had problem in the sid | at Resident #104's Lonhala as received at the facility on with the DON (director of at approximately 12:55 pm 104. DON stated she could dent #104's medications d. Allowing the physician's order of medications was diministrative team regional nurse consultant) 108/21/19 at approximately now approxim | {F6 | 84) | | |
| | | 1945 1941 | | | | |

Facility ID: VA0109

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

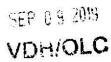
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 5586 10 | IPLE CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|--|---|---------------------|--|-------------------------------|----------------------------|
| | | | | | | R |
| | | 495320 | B. WING_ | | 0 | 8/21/2019 |
| | ROVIDER OR SUPPLIER E HALL CLINTWOOD | | | STREET ADDRESS, CITY, STATE, ZIP CO 1225 CLINTWOOD MAIN STREET, RO CLINTWOOD, VA 24228 | | 9 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| {F 684} | the entrance confe the surveyor reque were currently rece services. On 08/20/19, the D | proximately 11:55 a.m., during rence with the administrator, sted a list of residents that siving restorative nursing | {F 6 | 84} | | |
| | residents currently services. Resident listed on this facility then placed in the document was parevidence indicating audits of the reside nursing. Beside the | yor with a copy of a list of receiving restorative nursing #101 was the first resident y document. This resident was resident sample. This tof the facility's credible they had completed weekly ents receiving restorative eresident's name the facility check under the dates of D8/16. | | | | |
| | reviewed on 08/20 | R (electronic health record) was /19. The surveyor was unable n regards to restorative nursing | | | | |
| | the problem area t | nprehensive care plan included otal care. Approaches not limited to, physical hal therapy/restorative nursing d. | | ļ ļ | | |
| | the DON verbalizeresident's restoration discontinued on 0 being seen by restored not make it to due to human error (quality assurance | w with the DON on 08/20/19, d to the surveyor that the ve nursing services had been 7/26/19. However, she was still corative as the discontinue order the restorative tracking book or. The DON stated the QA) nurse was responsible for the ng for the POC (plan of | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID. VA0109

if continuation sheet Page 11 of 32



| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ELE CONSTRUCTION | | ATE SURVEY IMPLETED |
|--------------------------|---|--|---------------------|--|------------------------------|----------------------------|
| | | 495320 | B. WNG | | | 08/21/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI 1225 CLINTWOOD MAIN STREET, ROU CLINTWOOD, VA 24228 | | 9 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| {F 684} | copies of handwritte 07/26/19 by the faci discontinue restorat would be receiving of services. The DON in the resident's han On 08/20/19 during nurse, the QA nurse that she had not set discontinue the resi When asked if even received restorative physicians order the asked how she com restorative nursing nurse states she we "Restorative book." The DON provided the resident's "Rest the month of Augus indicated that this re motion to the right of from 08/01-08/19/10 08/01-08/07 and 08 Under the heading POC the facility had will be responsible The DON, ADON (a and/or Unit Manage Restorative Nursing for compliance. Any | N provided the surveyor with an orders transcribed on lity occupational therapist to live nursing as the resident DT (occupational therapy) stated this order was located dichart. an interview with the QA everbalized to the surveyor en the phone order to dent's restorative nursing, yone at the facility that nursing services had a e QA nurse stated yes. When appleted the audits for the part of the POC audits the QA ent by the book at the desk the little surveyor with a copy of orative Care Flow Record" for the 2019. This flow sheet esident had passive range of upper and lower extremities and transfer training on 1/08-08/15/19. Of "Monitoring" on the facility of documented that the "DON for maintaining compliance, assistant director of nursing) er will perform weekly grow sheets audits to monitor yold negative findings and eted at time of discovery and will be taken as | {F 68 | 4} | | |

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

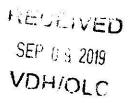
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 3 10 100 | IPLE CONSTRUCTION | (X3) DATE SURY COMPLETE | |
|--------------------------|--|--|--------------------|---|--|--------------------------|
| | | 495320 | B. WNG | | 08/21/2 | 019 |
| | ROMDER OR SUPPLIER E HALL CLINTWOOD | | | STREET ADDRESS, CITY, STAT 1225 CLINTWOOD MAIN STR CLINTWOOD, VA 24228 | E, ZIP CODE EET, ROUTE 607 PO BOX 909 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECT CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY) | (X5) MPLETION DATE |
| {F 684} | nurse consultant wer regarding Resident # services without a ph with their POC audits approximately 2:25 p No further informatio provided to the surve conference. | ON (director of nursing), and e notified of the issue 101 receiving restorative ysicians order and the issue on 08/21/19 at .m. In regarding this issue was by team prior to the exit | {F € | | | |
| (F 755) SS=D | S483.45(a)(b) §483.45 Pharmacy S The facility must produgs and biologicals them under an agree §483.70(g). The facility personnel to administ permits, but only undalicensed nurse. §483.45(a) Procedure pharmaceutical servithat assure the accudispensing, and administration biologicals in the facility. §483.45(b) Service (must employ or obtation pharmacist whospects of the provisithe facility. | dervices vide routine and emergency is to its residents, or obtain ament described in lity may permit unlicensed ter drugs if State law ler the general supervision of less. A facility must provide lices (including procedures rate acquiring, receiving, linistering of all drugs and the needs of each resident. Consultation. The facility in the services of a licensed less consultation on all sion of pharmacy services in lishes a system of records of | {F; | been notified that the ensure that the phy Magnair wasavaila administration. A Accident form has this incident. Identification of Corrective Action All residents may affected. A 100% medication orders the DON/designerisk. Residents for medications being pharmacy will be discovery and the will be notified. | he facility failed to resician ordered Lonhala able from pharmacy for facility Incident and been completed for | |
| | §483.45(b)(2) Estab receipt and dispositi | lishes a system of records of on of all controlled drugs in | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN 12

Facility ID: VA0109

If continuation sheet Page 13 of 32



PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|--------------------|--|---|
| | | | 1, 20,00 | | R |
| | | 495320 | B. WNG | The same and the s | 08/21/2019 |
| | ROVIDER OR SUPPLIER | 244 | | STREET ADDRESS, CITY, STATE, ZIP COD 1225 CLINTWOOD MAIN STREET, ROU CLINTWOOD, VA 24228 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE COMPLETION |
| {F 755} | sufficient detail to ena reconciliation; and §483.45(b)(3) Determ order and that an acc is maintained and per This REQUIREMENT by: Based on staff intervand facility document to ensure that routine medication administration for 1 cm and facility staff failer. The findings included the | nines that drug records are in count of all controlled drugs riodically reconciled. This not met as evidenced review, clinical record review treview the facility staff failed ons were available for if 13 residents, Resident | {F 7 | Systemic Changes: The Pharmacy Policy and Probeen reviewed and no changwarranted. All licensed nurs been inserviced on the Polic Procedure for medication acto included medications that unavailable or do not arrive timely from the pharmacy for administration. The inservice the steps the nurses should medication not be delivered the pharmacy. Monitoring: The DON is responsible for compliance. The DON/desic conduct weekly audits of reeach week to confirm the areall ordered drugs. All negatively medication in facility policy and/or practice. Completion Date: 9/13/19 | ing staff have y and liministration are at the facility or we will include take should a timely from maintaining gnee will sident MAR's vailability of ive findings of discovery, be reported to mittee for mendations y, procedure, |
| | | sessment reference date) of ne resident a BIMS (brief | | 3 | |

Facility ID. VA0109

PRINTED: 08/30/2019 FORM APPROVED

OMB NO. 0938-0391

| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. | Control of the Contro | | (X3) DATE SURVEY COMPLETED |
|--|--|--|---|--|
| | | 7202. | | R |
| | 495320 | B. MNG | | 08/21/2019 |
| ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | |
| | | | 1225 CLINTWOOD MAIN STREET, ROU | TE 607 PO BOX 909 |
| E HALL CLINTWOOD | | | CLINTWOOD, VA 24228 | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | | 10 TO | SHOULD BE COMPLETION |
| 25 A 25 / | | (F 7 | 755} | |
| interview for mental status) score of 14 out of 15 in section C, cognitive patterns. | | | | |
| clinical record was re signed physician's or read in part "Start: Li | viewed and contained a der dated 08/08/19, which onhala 25 mcg via neb | | | |
| administration record reviewed and contain part "Lonhala Magna hours". The entry for "N" on 08/10/19 and pm, and on 08/12/19 |) for August 2019 was led an entry, which read in ir 25 mcg starter Q 12 the Lonhala was coded with 08/11/19 at both 8 am and 8 and 08/13/19 at 8 am. The | | | |
| contained notes, while 8/10/19 Lonhala Maghouscheduled for 0 administered-Other.p clarification", "12:00/25 mcg Starter Q 12 08/10/2019 8:00 PM administered-Other.p clarification", "9:30AM 25mcg Starter Q 12 108/11/2019 8:00 AM pending provider clar Lonhala Magnair 25 houscheduled for 0 administered-Other.p clarification", "9:11 A 25 mcg Starter Q 12 | ch read in part. "9:06AM, mair 25 mcg starter Q 12 8/10/2019 8:00 AM was not bending provider AM, 8/11/19 Lonhala Magnair houscheduled for was not bending provider M 8/11/19 Lonhala Magnair houscheduled for was not administered-Other deciding results of the main and the magnair houscheduled for was not administered-Other deciding starter Q 12 18/11/2019 8:00 PM was not bending provider M 8/12/19 Lonhala Magnair houscheduled for | ¥ F | | |
| | CORRECTION ROVIDER OR SUPPLIER E HALL CLINTWOOD SUMMARY ST. (EACH DEFICIENC REGULATORY OR I CAREGULATORY OR I Continued From page interview for mental s in section C, cognitive The physician's order clinical record was re signed physician's or read in part "Start: Li (nebulizer) q12h (everalle in part "Lonhala Magna hours". The entry for "N" on 08/10/19 and ipm, and on 08/12/19 entry indicated that the administered. The notes section of contained notes, while 8/10/19 Lonhala Magna houscheduled for 0 administered-Other.pclarification", "12:00/25 mcg Starter Q 12 08/10/2019 8:00 PM administered-Other.pclarification", "9:30AM 25mcg Starter Q 12 08/11/2019 8:00 AM pending provider clar Lonhala Magnair 25 houscheduled for 0 administered-Other.pclarification", "9:11 A 25 mcg Starter Q 12 08/12/2019 8:00 AM | ROWDER OR SUPPLIER E HALL CLINTWOOD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) Continued From page 14 interview for mental status) score of 14 out of 15 in section C, cognitive patterns. The physician's orders section of Resident #104's clinical record was reviewed and contained a signed physician's order dated 08/08/19, which read in part "Start: Lonhala 25 mcg via neb (nebulizer) q12h (every 12 hours)". Resident #104's eMAR (electronic medication administration record) for August 2019 was reviewed and contained an entry, which read in part "Lonhala Magnair 25 mcg starter Q 12 hours". The entry for the Lonhala was coded with "N" on 08/10/19 and 08/11/19 at both 8 am and 8 pm, and on 08/12/19 and 08/13/19 at 8 am. The entry indicated that the medication was not | ROVIDER OR SUPPLIER E HALL CLINTWOOD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 interview for mental status) score of 14 out of 15 in section C, cognitive patterns. The physician's orders section of Resident #104's clinical record was reviewed and contained a signed physician's order dated 08/08/19, which read in part "Start: Lonhala 25 mcg via neb (nebulizer) q12h (every 12 hours)". Resident #104's eMAR (electronic medication administration record) for August 2019 was reviewed and contained an entry, which read in part "Lonhala Magnair 25 mcg starter Q 12 hours". The entry for the Lonhala was coded with "N" on 08/10/19 and 08/11/19 at both 8 am and 8 pm, and on 08/12/19 and 08/13/19 at 8 am. The entry indicated that the medication was not administered. The notes section of the eMAR was reviewed and contained notes, which read in part. "9:06AM, 8/10/19 Lonhala Magnair 25 mcg starter Q 12 houscheduled for 08/10/2019 8:00 AM was not administered-Other.pending provider clarification", "12:00AM, 8/11/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/10/2019 8:00 AM was not administered-Other.pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/11/2019 8:00 AM was not administered-Other.pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/11/2019 8:00 PM was not administered-Other.pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/11/2019 8:00 PM was not administered-Other.pending provider clarification", "9:11 AM 8/12/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/11/2019 8:00 PM was not administered-Other.pending provider clarification", "9:11 AM 8/12/19 Lonhala Magnair 25 mcg Starter Q 12 houscheduled for 08/11/2019 8:00 PM was not administered-Other.pending provider clarification", "9:11 AM 8/12/19 Lonhala Magnai | ROUDER OR SUPPLIER ### HALL CLINTWOOD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 interview for mental status) score of 14 out of 15 in section C, cognitive patterns. The physician's orders section of Resident #104's clinical record was reviewed and contained a signed physician's order dated D8/08/19, which read in part "Start: Lonhala 25 meg via neb (nebulizer) q124 (every 12 hours)". Resident #104's eMAR (electronic medication administration record) for August 2019 was reviewed and contained an entry, which read in part "Lonhala Magnair 25 meg starter Q 12 hours". The entry for the Lonhala was coded with "N" on 08/10/19 and 08/11/19 at both 8 am and 8 pm, and on 08/12/19 and 08/13/19 at 8 am. The entry indicated that the medication was not administered. The notes section of the eMAR was reviewed and contained notes, which read in part. "9:06AM. 87/10/19 Lonhala Magnair 25 meg starter Q 12 hours. Scheduled for 08/10/2019 8:00 AM was not administered-Other pending provider clarification", "12:00AM, 8:11/19 Lonhala Magnair 25 meg Starter Q 12 houscheduled for 08/11/2019 8:00 AM was not administered-Other pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25 meg Starter Q 12 houscheduled for 08/11/2019 8:00 AM was not administered-Other pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25 meg Starter Q 12 houscheduled for 08/11/2019 8:00 AM was not administered-Other pending provider clarification", "9:30AM 8/11/19 Lonhala Magnair 25 meg Starter Q 12 houscheduled for 08/11/2019 8:00 AM was not administered-Other pending provider clarification", "9:10AM 8/12/19 Lonhala Magnair 25 meg Starter Q 12 houscheduled for 08/11/2019 8:00 AM was not |

Facility ID VA0109

PRINTED: 08/30/2019 FORM APPROVED

OMB NO. 0938-0391

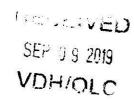
| | ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUI. A. BUILD | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|--|--|----------------------------|
| | | 495320 | B. WING | | 08/21/2019 |
| | ROVIDER OR SUPPLIER E HALL CLINTWOOD | | 10 (10 (10 (10 (10 (10 (10 (10 (10 (10 (| STREET ADDRESS, CITY, STATE, ZIP COD 1225 CLINTWOOD MAIN STREET, ROU CLINTWOOD, VA 24228 | E |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | SHOULD BE COMPLETION |
| {F 755} | and "11:43AM, 8/13/ Starter Q 12 housc AM was not administ clarification.pending a device to deliver the a The surveyor spoke of nurse) #1 on 08/21/1 regarding Resident # stated that the medic the pharmacy. Also s for the Lonhala to arr needing a special ne The surveyor spoke of 08/21/19 at approxim Resident #104's med stated the Brovana w the 9 pm pharmacy r 30-day supply of the time. Pharmacist #1 Lonhala was sent ou pharmacy run. Pharm Lonhala starter kit wa the 1 pm pharmacy r | on on order per pharmacy" 19 Lonhala Magnair 25 mcg heduled for 08/13/2019 8:00 ered-Other pending provider arrival form pharmacy the dose, MD notified". with LPN (licensed practical 9 at approximately 8:00 am 104's medications. LPN #1 ation was not available from stated was that it took longer ive from pharmacy due to | (F 7 | 755) | |
| | manifest for Residen the surveyor on 08/2 pm. The pharmacy n Resident #104's Lon facility on 08/09/19 a manifest indicated th | ted a copy of the pharmacy t #104. This was provided to 1/19 at approximately 2:10 hanifest indicated that hala refill was received at the t 12:16 AM. The pharmacy hat Resident #104's Lonhala has received at the facility on | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: TOJN12

Facility ID. VA0109

If continuation sheet Page 16 of 32



PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 3 2 2 | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|--|-----------|-------------------------------|--|
| | | 495320 | B. WING_ | | 0 | R 8/21/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| {F 755} | Continued From page | e 16 | ! {F 75 | 55) | | 85 85 | |
| | The surveyor spoke vertically regarding Resident # the resident's medical administration, she we notify the pharmacy for cannot not be delivered know the medication they want to order a consurveyor asked the Diphysician on call 24/7 do. The DON could of why the physician wall #104's medications in The surveyor request copy of a facility policy Shortages/Unavailable in part, "1. Upon discoinadequate supply of to a resident, facility similate action to obtain pharmacy. 4. If an emunavailable, facility in attending physician to 5. If the medication is or a third party pharmacy. | with the DON (director of at approximately 12:55 pm 104. The DON stated that if tions were not available for ould expect the nurse to or delivery. If the medication ed, call the MD to let them is not available, and to see if different medication. The ON if the facility has a ', and she stated that they ffer no explanation as to s not notified of Resident of being available. ed and was provided with a y entitled "Medication e Medications" which read covery that facility has an a medication to administer staff should immediately in the medication from hergency delivery is urse should contact the obtain orders or directions. I unavailable from pharmacy hacy, and cannot be supplied or, facility should obtain | | | | | |
| | necessary". | | H | | | 報 報 | |
| | the administrative tea regional nurse consu 08/21/19 at approxim | ration was discussed with im (administrator, DON, Itant) during a meeting on | n 5 | | | 10 COM (SEC.) | |
| | ivo futulei imolimatioi | was provided prior to exit. | | | | | |

Event ID: TOJN12

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 25/48/EW | | CONSTRUCTION | | SURVEY LETED |
|----------------------------|--|--|---|------|---|---|----------------------------|
| | | 495320 | B. WING | | | 08/ | 21/2019 |
| | ROVIDER OR SUPPLIER E HALL CLINTWOOD | * | STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE CLINTWOOD, VA 24228 | | | | |
| (X4) ID PREFIX TAG | FACH DEPICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| (F 758) (F 758) SS=D | Free from Unnec Psy CFR(s): 483.45(c)(3) §483.45(e) Psychotromy systems and behabut are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iv) Hypnotic Based on a comprel resident, the facility §483.45(e)(1) Reside psychotropic drugs unless the medication as in the clinical record systems are ceive gradule behavioral intervent contraindicated, in a drugs; §483.45(e)(3) Reside psychotropic drugs unless that medicated in the clinical record systems are limited to 14 days are limited to 14 days. | chotropic Meds/PRN Use (e)(1)-(5) opic Drugs. chotropic drug is any drug that is associated with mental vior. These drugs include, drugs in the following mensive assessment of a must ensure that— ents who have not used are not given these drugs on is necessary to treat a diagnosed and documented diagnosed and documented diagnosed ions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order ion is necessary to treat a condition that is documented | H Same | 758} | Corrective Action(s): Resident 107's attending physician was notified that facility staff failed to more the resident for side effects of the physician ordered Lexapro (escitalopr A facility Incident & Accident form we completed for this incident. Resident 106's attending physician was notified that facility staff failed to most the resident for side effects of the physician ordered trazadone. A facility Incident & Accident form was completed that facility staff failed to most the resident for side effects of the physician ordered trazadone. A facility staff failed to most the resident for side effects of the physician ordered citalopram. A facil Incident & Accident form was completed that facility staff failed to most the resident for side effects of the physician ordered citalopram. A facil Incident & Accident form was completed that incident. Identification of Deficient Practice and Corrective Action(s): All other residents receiving antidepressant medications may have been potentially affected. The DON/designee will review the medicorders of all residents receiving antidepressent medication to identify residents without appropriate psychotropic medication monitoring Any/all negative findings will be communicated to the attending phys for corrective action. A Facility Incident Accident form will be completed each negative finding. | am). as as nitor ty eted as onitor lity eted (s) cation | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA 3DENTIFICATION NUMBER: | 8 6 | | CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|---|---|--------------------|------|---|------------------------|----------------------------|
| AND LAR OF | SOURCESTION | | A. BUILDI | NG | | | R |
| | | 495320 | B. WNG | | | ſ | 8/21/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | (X) | 343 |
| | | * | | 12 | 25 CLINTWOOD MAIN STREET, ROUTE 607 PO | BQX 909 | 9 |
| HERITAG | E HALL CLINTWOOD | | | CI | LINTWOOD, VA 24228 | 22 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | 1000 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 758} | prescribing practition appropriate for the Pibeyond 14 days, he orationale in the reside indicate the duration §483.45(e)(5) PRN of drugs are limited to 1 renewed unless the apprescribing practition the appropriateness. This REQUIREMENT by: Based on staff interview, and clinical related to ensure that psychotropic medications were specific condition by the psychotropic meresidents, Residents. The findings included 1. For Resident #10 for the side effects of medication lexapro (previously identified annual survey for fail associated with this. The residents EHR is reviewed on 08/20 and A review of the residents and be Diagnoses on this fail approach in the residents and be Diagnoses on this failed and the polygons and the residents and the polygons and the residents and the polygons and the residents and the polygons and the polygons and the residents and the polygons and the polygons and the polygons and the polygons are the properties. | er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. orders for anti-psychotic (4 days and cannot be attending physician or her evaluates the resident for of that medication. This not met as evidenced view, facility document ecord review, the facility staff utions were not given unless enecessary to treat a monitoring for side effects of dications for 3 of 13 children and #108. d: The facility failed to monitor of the anti-depressant fescitalopram). This resident d as #45) was cited at the filing to monitor for side effects same medication. (electronic health record) was | {F 7 | 758) | Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staffwill be inserviced by the DON and regional nurse consultant and issued a copy of the facility policy and procedu for proper administration and monitoring for behaviors, side effects and effectiveness of psychotropic medications. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will complete weekly physician orders and MAR audits on a residents receiving psychotropic medications to monitor compliance. An egative findings will be corrected immediately and appropriate discipling action will be taken as necessary. Aggregate findings of these audits will provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 9/13/19 | re ng ng HI All ary be | • |

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROMDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING_ B. MNG 495320 08/21/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE. 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 HERITAGE HALL CLINTWOOD CLINTWOOD, VA 24228 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE. TAG TAG DEFICIENCY) (F 758) Continued From page 19 {F 758} hypertension, sleep apnea, generalized anxiety disorder, major depressive disorder, cognitive communication deficit, and delusional disorders. Section C (cognitive patterns) of the resident's quarterly MDS (minimum data set) assessment with and ARD (assessment reference date) of 07/12/19 included a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points. The resident's comprehensive care plan included the problems area mood/behavior/psychosocial wellbeing and psychotropic drug use. Approaches included, but were not limited to, notify MD of any changes, pharmacy reviews as needed, GDR (gradual dose reduction) as recommended, and administer medications as ordered by the physician. The resident's EHR included a physicians order for the anti-depressant medication escitalopram 20 mg tablet one po (by mouth) everyday. The diagnosis was documented as depression. A review of the resident's eMARs (electronic medication administration records) revealed that this medication was being administered daily at 8:00 a.m. The eMAR did not include any information to indicate the facility was monitoring for side effects of this medication. On 08/20/19 at 3:45 p.m., the DON (director of nursing) was asked for evidence of monitoring for side effects of the resident's psychotropic medications. On 08/20/19, the DON stated to the surveyor that

they had failed to monitor for side effects of the

PRINTED: 08/30/2019 FORM APPROVED

| CENTER | S FUR MEDICARE & | MEDICAID SERVICES | | | OMB | NO. 0938-0391 |
|--------------------------|---|---|------------------------|---|--|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
| | | 495320 | B. WING | | 0 | R 8/21/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | 200 | 200 | STREET ADDRESS, CITY, STATE | ZIP CODE | |
| HERITAGI | E HALL CLINTWOOD | | | 1225 CLINTWOOD MAIN STRE CLINTWOOD, VA 24228 | EET, ROUTE 607 PO BOX 909 | ı |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE IGIENCY) | (X5) COMPLETION DATE |
| {F 758} | Continued From pag- lexapro. | e 20 | {F 7 | 58) | | |
| | the surveyor that the did not let them key i would not "see any then added when the meetings they asked were. We would capt asked for evidence o AOC (allegation of cothe DON stated they | a.m., the DON verbalized to r system (computer system) in the side effects and we" for lexapro. The DON by held their care plan this resident what her goals are side effects. When f anything since the facility ompliance) date of 08/04/19 did not have anything. The procedures on sequence and medication | vi | į | | |
| | errors read in part, ". medication that has a consequence will be such consequences reported. An "advers | residents receiving any a potential for an adverse monitored to ensure that any are promptly identified and e consequence" is defined appropriate the consequence. | E . | | | |
| | psychotropic drug is brain activities associ and behaviorAll me | tion use read in part, "A any medication that affects iated with mental processes edications used to treat monitored forharm or | | | | |
| | "Corrective action: R Resident #107) after that facility staff failed side effects and effect ordered LexaproM responsible for main | n of correction) read in part, esident #45's (now known as eding physician was notified d to monitor Resident #45 for ctiveness of the physician conitoringThe DON is taining compliance. The ant director of nursing) and/or | | E E | | |

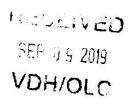
PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

| OLITICITY | OTOTT WEDIONALE & | MEDICAID SERVICES | | | OND NO. 0336-0331 |
|--------------------------|--|---|---------------------|---|-------------------|
| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | (X3) DATE SURVEY COMPLETED | |
| | | | | | R |
| | | 495320 | B. WNG | | 08/21/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | · | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | 9 |
| HEDITACI | THAT CUNTROOP | | 1225 | CLINTWOOD MAIN STREET, ROUTE 607 PO | BOX 909 |
| HERITAGE | E HALL CLINTWOOD | | CLII | NTWOOD, VA 24228 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | DITE |
| {F 758} | Continued From page | e 21 | (F 758) | | 2010. |
| | Unit Manager will cororders and MAR (me record) audits on all a psychotropic medical All negative findings immediatelyComplet The facility provided that audits had been and 08/15/19. The administrator, Denurse consultant were | nplete weekly physician dication administration residents receiving cions to monitor compliance. | (1.755) | | |
| | Approximately 2:25 p No further information provided to the surve conference. 2. The facility staff fa | n regarding this issue was by team prior to the exit filled to monitor Resident associated with the use of | | | E I |
| | was originally admitted with a re-admission of included but were no obstructive pulmonar emphysema, unspec | | F E e | | , |
| | reviewed on 08/21/19 (minimum data set) a assessment with an date) of 08/05/19. S | r Resident # 106 was 3. The most recent MDS assessment was a quarterly ARD (assessment reference ection C of the MDS atterns and Resident #106 | | | |

Event ID. TOJN12

Facility ID VA0109

If continuation sheet Page 22 of 32



PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

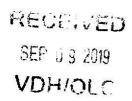
| | OF DEFICIENCIES CORRECTION | (X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 29 19990000 50 | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|--------------------|--|---|
| | | 495320 | B. WING | | R 08/21/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COU 1225 CLINTWOOD MAIN STREET, ROU CLINTWOOD, VA 24228 | DE |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE COMPLETION E APPROPRIATE DATE |
| {F 758} | had a BIMS (brief inte score of 15 out of 15. The current plan of ca reviewed and revised documented on 08/06 documented a proble "Mood/behavior/psycl (Resident's name) ha paranoid schizophren (disorder), conduct d/ (Resident #106's name such as yelling from conursing staff instead of exhibits with persistantie: male vendors com | erview for mental status) are for Resident #106 was with facility staff signatures i/19. The facility staff m area as, | {F 7 | | |
| | when room mates usi room. No behaviors of The care plan's intervincluded but were not effectiveness and side | r trash can, doesn't [sic] fike ng [sic] the commode in documented this r [sic]." entions/"approaches" limited to, "Evaluate effects of medications for mination of psychotropic | | | 2 2 2 2 2 2 2 |
| | were not limited to, "I tablet 1 po (by mouth bedtime)." On 08/21/" the August 2019 med (MAR) for Resident # documentation that To every night in August initials noted every night area for staff commer of Trazodone given, sfor "Pre Admin Antide" | 19, one surveyor reviewed ication administration record 106. The MAR included razodone had been given by a check mark and staff ght. The MAR included an its or notes. For each dose staff documented an answer | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID: VA0109

If continuation sheet Page 23 of 32



PRINTED: 08/30/2019 FORM APPROVED

OMB NO. 0938-0391

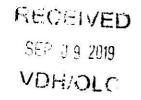
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|-------------------------|--|---|
| | | 495320 | B. WNG_ | | R 08/21/2019 |
| | ROVIDER OR SUPPLIER E HALL CLINTWOOD | | | STREET ADDRESS, CITY, STATE, ZIP CO 1225 CLINTWOOD MAIN STREET, RO CLINTWOOD, VA 24228 | ODE |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIJ TAG | | ON SHOULD BE COMPLETION HE APPROPRIATE DATE |
| (F 758) | | e 23 e effects of Trazodone. | {F 7 | 58) | |
| | 08/21/19 at 12:42 p.r. MAR documentation The DON stated the through their corpora anti-depressant beha effects monitoring. The expectation was to discoumented in the reviewed Resident # August 2019. The number Meeting was documented in the resident's behavior side effects specifical The facility's pharma "3.8 Psychotropic Meeting was documented in the resident's behavior of the facility's pharma "3.8 Psychotropic Meeting". | avior monitoring, not side The DON stated the iscuss side effects of any are plan meetings which were ursing notes. One surveyor 106's nurses notes for urses "Annual Care Plan mented on 08/08/19 and noted iors however, did not address | | | |
| | medications used to clinical indication and possible dose to ach effect. All medicatio should be monitored 7.3 Benefits, and 7 consequences." The facility's director and nurse consultant | treat behaviors must have a d be used in the lowest lieve the desired therapeutic ns used to treat behaviors for: 7.1 Efficacy, 7.2 Risks, 4 Harm or adverse of nursing, administrator, t were notified of the above during a meeting with the | | ¥ | |
| | team prior to the exi 3. For Resident #10 | 8 the facility staff failed to effects of the psychotropic | | 8 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: "CJN12

Facility ID: VA0109

If continuation sheet Page 24 of 32



| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | S 25 22 | TIPLE CONSTRUCTION | (| (X3) DATE SURVEY COMPLETED | |
|---|---|--|---|--|----------------------------------|-------------------------------|--|
| | | 495320 | B, WING | | | R | |
| NAME OF O | ROVIDER OR SUPPLIER | 493320 | B, 19114G_ | STREET ADDRESS, CITY, STATE, ZIP (| 1 | 08/21/2019 | |
| NAME OF E | NOWIDER OR SUFFEIER | | | 1225 CLINTWOOD MAIN STREET, R | | 3Y 000 | |
| HERITAG | E HALL CLINTWOOD | | | CLINTWOOD, VA 24228 | COOIL OUT FOR | 7V 203 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT | TION SHOULD BE THE APPROPRIAT | (X5) COMPLETION E DATE | |
| {F 758} | Continued From pa | age 24 | (F 7 | 58} | | | |
| | | hysician's Desk Reference, dication used to treat | <i>20</i> | | | | |
| | date of 03/20/07 at 02/02/19. The resid diagnoses, which i seizure disorder, h hyperlipidemia, de intellectual disabilit | ce sheet listed an admission and a readmission date of dent's diagnosis list indicated noluded, but not limited to ypertension, anemia, pression, dysphagia, ties, altered mental status, digastroesophageal reflux | | | | | |
| | , disorder. | | | | | 8 | |
| | (minimum data set reference date) of a BIMS (brief inter | ost recent quarterly MDS) with an ARD (assessment 08/04/19 assigned the resident view for mental status) score of tion C, cognitive patterns. | E 6 F 6 F 6 F 6 F 6 F 6 F 6 F 6 F 6 F 6 | | | | |
| | clinical record was contained a physic month of August 2 | ders section of the resident's reviewed on 08/21/19. It identifies the control of the 019, which read in part 20 mg tablet. 1 tablet po (by pression)". | | | | | |
| | administration reco was reviewed and in part "Citalopram daily for depressio given per physicial | MAR (electronic medication ord) for the month of August contained an entry, which read HBR 20 mg tablet. 1 Tablet po n. This entry was initialed as n's orders. The surveyor could nitoring off side effects of this | | | | | |
| | normalisates and from notifical provided life for the first fill of the | th the DON (director of | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | IPLE CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---------------------|--|--|----------------------------|
| | | 495320 | B, WNG_ | and the second s | | ₹ 21/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PC CLINTWOOD, VA 24228 | 10. 1001.010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY) | BE | (X5) COMPLETION DATE |
| {F 761} SS=D | stated, "We are not measure to policy entitled "Advented Medication Errors" where the second policy entitled "Advented Medication Errors" where the second potential for an adverted are promptly identified adverse consequence unpleasant symptom associated with a mean impairment or declined physical condition or status. An adverse of Side effect." The concern of not mean the psychotropic mean discussed with the accordance of the properties of the psychotropic mean (administrator, DON, during a meeting on the psychotropic meeting on the psychot | nonitoring for side effects. and was provided with a se Consequences and nich read in part, "1. any medication that has a se consequence will be hat any such consequences d and reported. 2. An e' is defined as an or event that is due to or dication, such as an e in an individual's mental or functional or psychosocial onsequence may include: b. sonitoring for side effects of dication citalopram was deministrative team regional nurse consultant) 28/21/19 at approximately an was provided prior to exit. and Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be e with currently accepted es, and include the | {F7 | F761 | odyl re ident ed for m has | |

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES | | (X1) PROMOER/SUPPLIER/CLIA | (X2) MULTIPLE C | (X3) DATE | (X3) DATE SURVEY | | |
|---|--|--|-----------------|--|------------------|---|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER. | | . BUILDING | | COMPLETED | |
| | A, 30121113 | | R | | | | |
| | | 495320 | B, WING | 25 <u>17 17 17 17 17 17 17 17 17 17 17 17 17 1</u> | 08/: | 21/2019 | |
| NAME OF PE | ROVIDER OR SUPPLIER | | I str | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| MAME OF FI | KONIDER OR DOLLER | * | | 25 CLINTWOOD MAIN STREET, ROUTE 607 P | O BOX 909 | | |
| HERITAGE | HALL CLINTWOOD | | I) | JNTWOOD, VA 24228 | | | |
| *************************************** | | William Belle and the second of the second o | | ANGER OF THE PROPERTY OF THE P | N1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| {F 761} | §483.45(h)(1) In acc | cordance with State and | {F 761} | Identification of Deficient Practice Corrective Action(s): All unit medication rooms, medication refrigerators and medication carts us the storage medications may have be | on ed for | | |
| | | cility must store all drugs and | | potentially affected. The DON, ADO |)N | | |
| | | compartments under proper s, and permit only authorized | | and/or Unit Manager will conduct a | 100% | | |
| | personnel to have a | | | review of the medication room, | | | |
| | personner to nave a | ccess to the keys. | | medication carts, and medication | | | |
| | 8483 45(h)(2) The f | acility must provide separately | | refrigerators to identify any expired, | | | |
| | | affixed compartments for | 1 | undated or loose medications; and w | /ill | | |
| | | d drugs listed in Schedule II of | | review all med room refrigerators to | , | | |
| | | Drug Abuse Prevention and | | ensure that the narcotic lock boxes a | re | | |
| | | and other drugs subject to | | permanently affixed to the inside of | the | | |
| | | the facility uses single unit | | refrigerator. Any/all negative findir | ıgs | | |
| | | oution systems in which the | | will be corrected at time of discover | y. A. | | |
| | | inimal and a missing dose can | le . | Facility Incident and Accident Form | i Wili | | |
| | be readily detected. | | Î | be completed for each incident iden | meu. | | |
| ā. | | NT is not met as evidenced | | | | | |
| | by: | | | Systemic Change(s): | | | |
| | 4 | ions, staff interview, and | | Facility policy and procedure for | 0114 | | |
| | | view the facility staff stored | | medication and biological storage h | ave | ì | |
| The Country of | | s in 1 of 2 medication rooms | 8 | been reviewed and no changes are warranted at this time. All licensed | nurcec | | |
| | | on carts and also failed to | j | will be inserviced by the DON on the | ne nation | | |
| | 8 | box was permanently affixed | i | facility policy and procedure for sto | vrino | | |
| | The state of the s | 1 of 2 medication rooms. | | medications and biologicals. The medications are biologicals to staff will also be inserviced on the | ırsing | | |
| | The findings include | ed: | | Medication Administration Policy a | and v of all | | |
| | The facility staff fail | ed to date opened lidocaine | 1 1 | Medication rooms, medication | | | |
| | | I to discard outdated niacin, | | refrigerators and medication carts f | or | | |
| | | gel, bisacodyl stimulant | | medications to include injectables | and | | |
| | | ofen and failed to secure | | unrefrigerated medications and | | 1 | |
| | refrigerated ABH ge | | | biologicals that may be expired or | opened | | |
| | | | ot. | with no date or laying loose in the | | | |
| | On 8/21/19 at 10:39 | 5 a.m. two surveyors along | i . | medication carts. In addition, The | 21 | | |
| | | ployee, a licensed practical | 1 | Pharmacy consultant will check ea | ch | 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | |
| | nurse (LPN #1) oh | served medication storage | | medication room and each medicat | | | |
| | | cked medication storage room | | cart for improper storage of medica | itions | | |
| | referred to as the " | eft side medication room." In | | during scheduled visits | | Ì | |
| | | two bottles of Niacin (an over | 5 | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID. VA0109

If continuation sheet Page 27 of 32



| CENTEROT OF MEDICALES | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|--|----------------------------|--|--|------------------|----------------------------|--|
| | | IDENTIFICATION NUMBERS | | A. BUILDING | | | COMPLETED | |
| | | | A. BOILDING | | | R | | |
| | | 495320 | B. WNG_ | | | | 1/2019 | |
| NAME OF SOOTS | חם לוויסט יולים | 733320 | | STREET ADDRESS, CITY, STATE, ZIP CODE | L | J 41 Z | | |
| NAME OF PROVIDER | UK BUFFLIEK | × | | 1225 CLINTWOOD MAIN STREET, ROUTE | 07 PO BOX | 909 | | |
| HERITAGE HALL CLINTWOOD | | | | CLINTWOOD, VA 24228 | | | | |
| 35 25 35 35 35 35 35 35 35 35 35 35 35 35 35 | 200000 | | | | CTICN | | eves. | |
| | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | | (X5) COMPLETION DATE | |
| the contablets expirate redical vancould discarding the content of | seach were for tion dates print ation refrigerat mycin 7.5 g (a d after 7/31/19 mpled Residen ent #115 was ration, acknowlexpired, and set the Nacin and the "drug busterator containes at a the Nacin and the "drug busterator containes at the 12 mg, 12 mg) that had 19 and was latent #114. The bunted 28 syring PN #1 acknowled and stated the dABH gel was a g (DON) would acked box that termanently affitives able to picture while objects. LPN #1 acknowled and stated the counter while objects. LPN #1 acknowled and stated the counter while objects. LPN #1 acknowled and stated to be set of the counter while objects. LPN #1 acknowled and stated the counter while objects. LPN #1 acknowled and the counter while objects. LPN #1 acknowled and the counter while objects to be set of the counter while objects at the "rillant Laxative (cation) was found in the counter was found in the counter was a set of the cation) was found in the cation was f | pe 27 upplement) 100 mg, 100 und and both bottles had ted as "07/19." The locked or had a bottle of liquid n antibiotic) that read to . The bottle was labeled for it #115. The LPN stated no longer receiving the edged that both medications aid another nurse would I Vancomycin with her in er" or sharps container. The d a locked box with a brown ntained "ABH Gel Topical" Benadryl 12.5 mg, and d an expiration date of beled for un-sampled LPN emptied the brown bag nges, 1 ml each, of the ABH idedged the medication had the process of handling the state facility director of d waste it with another nurse, contained the ABH gel was exed to the refrigerator; the k the box up and place it on serving and counting the cknowledged the locked box bolted within the refrigerator. a.m., two surveyors n storage and labeling with a PN #2) on a medication cart ght hall back cart." Bisacodyl an over the counter ind with an expiration date N #2 acknowledged the ired and said she would take | {F 76 | Monitoring: The DON is responsible for main compliance. The DON/designed perform weekly Medication room Medication cartaudits to monitor compliance. All discrepancies for these audits will be corrected at the of discovery and disciplinary act as appropriate. Results of these abe reported to the Quality Assurt Committee for review, analysis, recommendations for change in policy, procedure, and/or practice Completion Date: 9/13/19 | will n and for und in he time ion taken udits will ance and facility | | | |

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

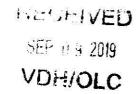
| CENTERS FO | IN MEDICARE & | MEDICAID SERVICES | | | ONID NO. 0930-0391 |
|---|--|---|---------------------------------------|---|--------------------|
| STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (A. BUILDING | (X3) DATE SURVEY COMPLETED | |
| | | 495320 | B. WNG | 1000 | R 08/21/2019 |
| NAME OF PROVID | ER OR SUPPLIER | | STI | REET ADDRESS, CITY, STATE, ZIP CODE | |
| HERITAGE HALL CLINTWOOD | | | 12: | 25 CLINTWOOD MAIN STREET, ROUTE 607 | PO BOX 909 |
| HERITAGE HAL | LE CLINTWOOD | | CL | INTWOOD, VA 24228 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROMDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLETION |
| {F 761} Cor | ntinued From pag | ne 28 | {F 761} | | |
| | waste the vial with the DON in the "drug buster" making sure there were two witnesses. | | 2 | | |
| | | | | | |
| 0 | 00/01/10 at 1:00 | n m and survivious observed | | | |
| | | p.m., one surveyor observed and labeling with a facility | | | |
| | AND THE RESIDENCE OF THE PROPERTY OF THE PROPE | | Ē. | | |
| | employee (LPN #3) on a medication cart referred to as the "left hall front cart." Two vials of | | | | |
| | Lidocaine HCL 1% 200mg/20 cc (multi dose vials) | | | | |
| wer | were observed with both lids/tops off and both | | | | |
| | rubber septums visible. There was no date | | | | |
| | written on either vial that would indicate when it | | | | |
| | had been opened. One of the vials had a manufacturer's printed expiration date that read, | | | | |
| | | | | | |
| | | e other read. "1 Aug 2020." e nurse would know when the | | | |
| | | PN #3 said they could be | | | |
| | The second secon | nat was printed on them. | · · · · · · · · · · · · · · · · · · · | | 8 |
| | | ed the vials were open and | | | |
| the | re was no way of | knowing what date they had | | | |
| bee | been opened. Ibuprofen Oral Suspension | | | | |
| | | erved on the medication cart | | | |
| | erne de falling e et en andere e vers a ffine e ar fillige e det an traverse — de tarban | ate that read, "05/19." LPN | | | |
| | Manager 1 M Tax 6 mm | e medication was expired | | | |
| | | return it to the medication er nurse to dispose of the | | | * |
| | m and see anoth pired medications | | | | |
| evb | nied inedications | | ÷: | | |
| On | 08/21/19 at 2:05 | p.m., the facility's quality | | | |
| | | se, LPN #4, was interviewed | | | |
| | | om. LPN #4 acknowledged | | | |
| | being the nurse responsible to check for expired medications and stated she performed the | | | | |
| | | | | | |
| | | basis. When informed there | | | |
| | | ations found, LPN #4 stated, | | | |
| "I g time | | d them when I checked last | | | |
| um | c . | | | | |
| The | e facility's director | r of nursing, administrator, | | | |
| | AT THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED I | t were notified of the | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID: VA0109

If continuation sheet Page 29 of 32



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---|---------|--|--|--|
| | | 495320 | B, WING | | R 08/21/2019 | | |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD | | | | 1225 CI | T ADDRESS, CITY, STATE, ZIP CODE LINTWOOD MAIN STREET, ROUTE 607 PO E WOOD, VA 24228 | | |
| (X4) ID PREHX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | (D PREFI) TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | Discours and the second | |
| {F 761} | meeting with the survey. On 08/21/19 at 3:12 p pharmacist was interversely facility's conference re the expectation for mit Lidocaine HCI 1%, was "popped" on it, whether | ey team on 08/21/19 at 2:28 e.m., the facility's consultant viewed in person in the foom. The pharmacist stated alti-dose vials, such as as that once the top was er the septum was ust be dated and then it | {F 7 | 51} | | | |
| | The facility's nurse copharmacy (Omnicare) and Expiration of Med Syringes and Needles that read in part, "4. I medications and biolo expired date on the la longer than recomme supplier guidelines; or contaminated or deterfrom other medication returned to the pharm Once any medication opened, Facility should manufacturer/supplier expiration dates for opstaff should record the medication container shortened expiration of Facility staff may record to date based on date of container." The facility Medications" was revipolicy did not address within the refrigerators | insultant provided a policy titled, "5.3 Storage dications, Biologicals, "" on 08/21/19 at 3:20 p.m. Facility should ensure that ogicals that: (1) have an obel; (2) have been retained noted by manufacturer or (3) have been riorated, are stored separate as until destroyed or lacy or supplier." And "5. or biological package is lid follow reguidelines with respect to be pend medications. Facility | | | | | |

PRINTED: 08/30/2019 FORM APPROVED OMB NO. 0938-0391

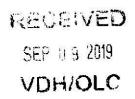
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--|------|---|--|-----------------------|-------|
| | | 495320 | B, WNG | | | | R 08/21/2019 | ĵ |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD | | | <u> </u> | 1225 | ET ADDRESS, CITY, STATE, ZIP CODE CLINTWOOD MAIN STREET, ROUTE 60 TWOOD, VA 24228 | 7 PO BOX | 909 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (XS) COMPLE DAT | ETION |
| F 867 SS=F | Continued From pag consultant said there addressed the locker refrigerator. No further information team prior to the exit QAPI/QAA Improver CFR(s): 483.75(g)(2) \$483.75(g) Quality at \$483.75(g) Quality at \$483.75(g)(2) The quassurance committed (ii) Develop and implication to correct identified This REQUIREMEN by: Based on observation document review, at facility staff failed to program meet the nevidenced by repeat of Resident Assessing Pharmacy Services monitor the effects of make needed revisite. | e 30 e was no other policy that d narcotics box in the on was provided to the survey t conference. nent Activities)(ii) assessment and assurance. uality assessment and be must: lement appropriate plans of ntified quality deficiencies; IT is not met as evidenced ion, staff interview, facility and clinical record review, the ensure the quality assurance eeds of the facility as ted deficiencies in the areas ment, Quality of Care, and and failed to effectively of implemented changes and ons to the action plans as ention of further deficiencies. | {F : | 867 | | ity has dures al lude e, active storage ion actices & to be onitoring res. All essed by the dits and n will be | of | |
| | identified deficient p | ey process, the survey team practice in the areas of ent, Quality of Care, and i. | | | | | | |
| | reviewed the facility | he DON (director of nursing) y QA (quality assurance) (quality assurance and | | | | 20002 | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID: VA0109

If continuation sheet Page 31 of 32



PRINTED: 08/30/2019 FORM APPROVED

| OFNITTO | C COD MEDICADE 8 | MEDICAID SERVICES | | | OMB NO. 0938-0391 |
|---|--|--|--|---|---|
| ACT OF CONTRACT | The same Colored managers are served | MEDICAID SERVICES | WELL THE | N.C. CONCERNICATION | (X3) DATE SURVEY |
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | STATE OF THE PARTY | PLE CONSTRUCTION G | COMPLETED |
| | | 495320 | B. WING | | 08/21/2019 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | (0) | | 1225 CLINTWOOD MAIN STREET, ROUTE | E 607 PO BOX 909 |
| HERITAGE HALL CLINTWOOD | | | | CLINTWOOD, VA 24228 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETION |
| F 867 | O8/21/19 at 1:00 p.m. The facility policy title Performance Improvement Prografacility's commitmen improvement. The performance evaluation of imachieve our perform. The administrator, Desire a meeting with the separation of the separation of the regarding their quality a meeting with the separation of the separatio | ed, "Quality Assurance rement" read in part, "Our not Performance rement out to continuous quality rogram ensures a systematic tion, problem analysis and reprovement strategies to ance goals" FON (director of nursing), and re notified of the issues ty assurance program during urvey team on 08/21/19 at o.m. | F 80 | Systemic Change(s): The QA Committee will take visible role in the day-to-day of the facility. Routine weekl of the medical records focusin Psychotropic Medication usag Care and Staff training related Dementia Management, Comp Resident Care Plans, Resident Assessment will be conducted compliance. All negative find addressed via a QA Action Pl concerns. They will monitor a resident care and services for quality improvements. Monitoring: The administrator is responsil maintaining compliance. The V.P. of Operations and/or Reg Consultant will visit the facility provide management and ope oversight per corporate direct Regional Director of Operation provide detail reports of negative Corporate Office for imme corrections. These findings we forward to Corporate for revisand recommendations for chafacility policy, procedure, and Completion Date: 9/13/19 | operations by QA audits ag on ge, Dementia I to prehensive t I to assure lings will be an to resolve all aspects of continuous ble for Regional gional Nurse ity weekly to crational cion. The cons will tive findings diate vill be ew, analysis, ange in |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOJN12

Facility ID. VA0109

If continuation sheet Page 32 of 32

